7. Is aprotinin exposure a consideration, given its trend to protect against atrial fibrillation after coronary surgery?[2]
8. Is hyperglycemia a possible confounder, given its association with higher rates of atrial fibrillation after cardiac surgery?[3] Was there a standardized approach to perioperative glucose management? Insulin therapy has been shown to be protective against postoperative atrial fibrillation.[4]
9. Was perioperative magnesium therapy standardized, given its link with the incidence of atrial fibrillation after cardiac surgery?[5]

I congratulate the authors again on a most excellent study. I look forward to their feedback about these considerations.

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Reply to the Editor:

We appreciate the comments of Dr Augoustides regarding our recent article[1] and would like to point out the following issues in response to his considerations.

The placement of the thoracic epidural anesthesia (TEA) catheter at the day before surgical intervention was recommended based on study protocol to control any acute catheter-related complications. Fortunately, we did not have any neurological or respiratory complications in the TEA group during our study.[1] In case of any important complication, the patient would be excluded from the study. In case of any bleeding complication, we would not recommend to reselect another epidural space.[2]

Sensory block levels were determined bilaterally by using loss of warm/cold sensation, as well as pinprick discrimination. The levels of motor block were estimated in the outplaced left arm by using an epidural anesthesia-scoring scale for arm movements. Both sensory and motor block were checked in 5-minute intervals until the desired anesthetic level was established.

The study protocol did not contain any medication prophylaxis, such as a β-blocker, against atrial fibrillation (AF). Thirty-two patients in the general anesthesia group and 35 patients in the general anesthesia plus TEA group had a medication with a β-blocker. It is well known that female sex is one of the most predictive risk factors for postoperative nausea and vomiting, and the results of our study confirm the value of this specific risk factor.[3] The power calculation for this study was 0.90, with an error probability of 0.50. We share the opinion with Dr Augoustides that, based on recent literature, the use of aprotinin in some schema, such as the Hammersmith strict perioperative management of hyperglycemias, might have some protective effect on prophylaxis of AF in patients undergoing coronary bypass surgery.

There was a standard approach to manage perioperative hyperglycemias by using insulin therapy to achieve blood glucose values of less than 120 mg/dL. The study protocol did not contain any medication prophylaxis of magnesium against AF.

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Effect of eliminating daily routine chest radiographs on on-demand radiograph practice in post–cardiothoracic surgery patients

To the Editor:

We read with great interest the recent article by Mets and colleagues[1] describing the results of a study comparing the effects of a routine versus on-demand chest x-ray approach in postoperative cardiothoracic surgery patients. The authors conclude that the on-demand approach led to a reduction in the number of chest radiographs performed without changing x-ray practice on their post—intensive care unit.

The practice of routine daily chest radiographs has been frequently questioned in the past.[2] The authors themselves have documented a low number of unexpected findings in routine chest radiographs and a low impact of these finding on further therapy.[3,4] As mentioned in the article, the authors have therefore abandoned daily routine chest radiographs for all patients in the intensive care unit. All the more surprising is the fact that this study was performed in a prospective comparative fashion and that the ethics committee deemed it unnecessary to obtain informed consent.

The quoted recommendations by the American College of Radiology as a scientific basis for daily routine chest radiographs